

U.S. Naval Hospital Naples, Italy
Infertility Questionnaire

The following questions make up a screening questionnaire that will help us in caring for you during your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. If you have any questions, please ask your health care provider.

Name _____ SSN of sponsor _____

Rank/Rate(active duty) _____ Duty Station _____ Phone# (H) _____ (W) _____

Age _____ HT _____ (Pre-pregnancy) WT _____ Race _____ Religious Preference _____

Primary Language _____ Single _____ Married _____ Divorced _____ Widowed _____

Name of Baby's Father _____ Rank/Rate _____ Race _____ Age _____

Duty Station _____ Phone # _____

Fertility History

- | | Yes | No |
|---|-------|-------|
| 1. Have you had an infertility work up in the last year? | _____ | _____ |
| 2. Have you taken infertility drugs in the past year? | _____ | _____ |
| 3. Had you been using birth control prior to conception?
(i.e. Pill, IUD, foam, condom, diaphragm, sponge, rhythm method)
Circle all that apply. When did you stop? _____ | _____ | _____ |
| 4. How long have you had unprotected intercourse to become pregnant?
_____ months or _____ years | | |
| 5. How many times per week do you have unprotected intercourse? _____ x / wk | | |

Medical History

- | | Yes | No |
|---|-------|-------|
| 1. Have you ever been hospitalized
If so, for what diagnosis
_____ | _____ | _____ |
| 2. Do you have any chronic health problems? | _____ | _____ |
| 3. Do you routinely have headaches, (prior to pregnancy)? | _____ | _____ |
| 4. Do you have, or have you ever had, seizures or convulsions? | _____ | _____ |
| 5. Do you have any problems with your vision or eyes?
(not including wearing contacts or glasses) | _____ | _____ |
| 6. Have you ever had problems with your thyroid gland?
What? _____ | _____ | _____ |
| 7. Have you ever had problems with your lungs?
(i.e. pneumonia, asthma, bronchitis, tuberculosis) | _____ | _____ |
| 8. Have you ever had problems with your heart?
(i.e. heart murmur, rheumatic heart disease, heart surgery,
"heart attack", high blood pressure) | _____ | _____ |

Medical History continued**Yes No**

9. Do you have problems with your stomach or intestines,
i.e. constipation, diarrhea, hemorrhoids (before pregnancy)? _____
10. Have you ever had a blood transfusion?
When? _____
11. Have you been told by a health care provider that you are anemic?
When? _____
12. Are you seeing a health care provider
for problems with your muscles or bones? _____
13. Have you had any mental or psychiatric problems that required counseling? _____
14. Do you have any other health problems that we should know about?
Explain: _____

15. Have you had or been immunized for:
a. Rubella (German measles or 3 day measles) _____
b. Rubeola (two week, hard, or red measles) _____
c. Varicella (Chicken Pox) _____
d. Hepatitis B _____
e. Hepatitis A _____
16. Have you ever had a positive PPD?
Were you treated? _____

Medications

1. Do you take any medications routinely? _____
What and how often? _____

Allergies**Yes No**

1. Do you have allergies to any medications?
If yes, which medication and what type of reaction? _____

4. Do you have allergies to any foods? _____
5. Do you have a latex allergy? _____

Surgical history

1. Have you ever had any operations or surgeries?
What and when? _____

PATIENT IDENTIFICATION _____

Social History

- | | Yes | No |
|---|-------|-------|
| 1. Do you smoke?
How many packs/day? _____ How many years? _____ | _____ | _____ |
| 2. Do you drink alcoholic beverages?
How many drinks/week? _____ | _____ | _____ |
| 3. Do you/have you used illicit or illegal drugs
if so, what _____ | _____ | _____ |
| 4. Are you currently employed
if so, what _____
What type of job? _____ | _____ | _____ |
| 5. Do you have heat in your home? | _____ | _____ |
| 6. Do you have a phone in your home? | _____ | _____ |
| 7. Have you ever been the victim of sexual, physical or emotional abuse? | _____ | _____ |

Obstetric History

Number of past pregnancies _____

1. Number of miscarriages and/or abortions _____
2. Number of children now living _____
If yes, answer date (chronological order), weight, method of delivery and any complications.

3. Have you ever received Rhogam? _____

Gynecologic & Menstrual History

- | | Yes | No |
|---|-------|-------|
| 1. Age at first menstrual period _____ | | |
| 2. How often are your periods? Every _____ days, lasting _____ days. | | |
| 3. Do you usually have severe cramping with your periods? _____ | | |
| 4. What was the first day of your last NORMAL period? _____ | | |
| 5. Have you had the following: | | |
| a. unusual breast lumps or discharge from the nipples | _____ | _____ |
| b. repeated vaginal infections, pelvic inflammatory disease | _____ | _____ |
| c. abnormal pap smears | _____ | _____ |
| d. sexually transmitted diseases | _____ | _____ |
| e. infections of the uterus, tubes or ovaries | _____ | _____ |
| f. abnormal hair growth pattern, fascial hair, excessive body hair? | _____ | _____ |
| g. surgery of your tubes, ovaries, uterus or vagina | _____ | _____ |
| h. pain with intercourse | _____ | _____ |
| i. use of gels or lubricants during intercourse? | _____ | _____ |
| j. diagnosis of fibroids, DES exposure, ectopic pregnancy. Circle appropriate | _____ | _____ |

PATIENT IDENTIFICATION _____

Educational History

1. How many years of school have you completed? _____
2. How many years of school has your partner completed? _____
3. Do you plan on taking childbirth preparation classes? _____

Family History

1. Do you or the father of the baby have any close family members with:

	Yes	No		Yes	No
diabetes	_____	_____	cancer	_____	_____
tuberculosis	_____	_____	high blood pressure	_____	_____
heart attack	_____	_____	heart problems	_____	_____
twins	_____	_____	bleeding problems	_____	_____
cystic fibrosis	_____	_____	Down's syndrome	_____	_____
hemophilia	_____	_____	mental retardation	_____	_____
spina bifida	_____	_____	muscular dystrophy	_____	_____
anencephaly	_____	_____	hydrocephalus	_____	_____
2. Will you be 35 or older when this baby is due? _____
3. Do you or the baby's father have any known birth defects?
Please list: _____
4. Have you or the baby's father had a child born (alive or dead)
with a birth defect not listed in the above questions? _____
5. Are there any known inherited or chromosomal
disorders in the family? _____
6. Are you and the baby's father related outside of marriage?
(such as cousins) _____

Genetic History

- | | Yes | No |
|---|-------|-------|
| 1. Are you or the father of the baby of African American descent?
Have you been tested for sickle cell trait?
Were the results positive? | _____ | _____ |
| 2. Are you or the father of the baby of Eastern European Jewish descent?
Have you been tested for Tay-Sachs carrier?
Were the results positive? | _____ | _____ |
| 3. Are you or the father of the baby of Asian or Mediterranean descent?
Have you been tested for Thalassemia trait?
Were the results positive? | _____ | _____ |
| 4. Any history of Cystic Fibrosis in your or your partner's family? | _____ | _____ |
| 5. Any history of mental retardation in your or your partner's family? | _____ | _____ |
| 6. Are there any other genetic abnormalities in your or your partner's
family history? | _____ | _____ |

PATIENT IDENTIFICATION

Male history

	Yes	No
1. How long has he been your partner? _____		
2. Has he fathered other children?	___	___
a. If yes, how many _____		
3. Past medical history _____		

4. Past surgeries?	___	___
a. If yes, what type(s) _____		

5. Has he been exposed to radiation?	___	___
6. Has he been exposed to hazardous chemicals?	___	___
a. If yes, what types? _____		

7. Any trauma or surgery to his genitalia/testicles?	___	___
8. Any history of sexually transmitted diseases?	___	___
9. Any history of mumps?	___	___
10. Any problems with ejaculation or erection?	___	___
11. Is he taking any medications?	___	___
a. If yes, what types? _____		

I have completed this History and Physical form to the best of my knowledge. Failure to provide adequate and/or truthful information could adversely affect my physician's ability to treat my infertility and inadvertently have a negative impact on my health and well being.

Patient signature

Date

I have reviewed the following History and Physical form provided by the patient listed.

Physician signature

Date

PATIENT IDENTIFICATION